

CASE REPORT

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Attempted Suicide by Cop: A Case Study of Traumatic Brain Injury and the Insanity Defense

ABSTRACT: Over the years, there have been a number of well-publicized incidents involving persons who seemingly maneuver police officers into shooting them. Such cases, while relatively rare compared with most forms of violence, nevertheless pose difficult challenges to law enforcement agencies. Relatively little is known about persons who engage in suicide by cop incidents. To our knowledge, there has been no published in-depth research on instigators of suicide by cop who survived. In this paper, we present a case study of an individual who engaged in and lived through three separate "attempted suicide by cop" incidents. After describing relevant history as well as events of the most recent incident, we compare the case with the extant literature on suicide by cop and analyze commonalities and differences. Finally, we examine the legal considerations involved, with particular attention devoted to the role the individual's traumatic brain injury played in applying the insanity defense.

KEYWORDS: forensic science, suicide by cop, police-assisted suicide, forensic psychiatry, forensic psychology, traumatic brain injury, frontal lobe dysfunction, insanity defense

Over the years, there have been a number of well-publicized incidents involving persons who seemingly maneuver police officers into shooting them. Such cases, while relatively rare compared with most forms of violence (1), nevertheless pose difficult challenges to law enforcement agencies. "Suicide by cop" denotes an incident in which an individual engages in high-risk behaviors intended to precipitate the use of deadly force by law enforcement agents toward that individual (2). These incidents often begin with the suicidal person intentionally engaging in some life-threatening activity or crime (1,3), typically wielding a lethal weapon, and demanding the attention of police (e.g., robbery, domestic assault, high speed chase). These suicidal individuals then "up the ante" by threatening officers and/or civilians, which, in turn, offer police little choice but to shoot the provocateur in self-defense and/or to protect civilians.

In a classic article on the subject, Wolfgang speculated from a psychodynamic perspective that individuals who engaged in "suicide by means of victim-precipitated homicide" reflected two death wishes: the desire to kill the person who is frustrating him; and the desire to kill himself (4). Some have noted that it is difficult to evaluate a suicidal individual's intentions even with reliable reports on personal history and previous behavior because such speculation is always ad hoc (5). Still, efforts at understanding the motivations of individuals who provoke suicide by cop incidents have been made. Recently, Mohandie and Meloy (1) examined research on motiva-

tions for high risk behavior such as suicide and violence, and delineated two categories of motivations for suicide by cop incidents: instrumental and expressive. The instrumental category includes purposeful and planned violent behavior whereas the expressive category characterizes suicidal behaviors which stem from hostile impulsivity because an individual feels overwhelmed, frustrated or threatened in some manner. With respect to suicide by cop incidents, instrumental motivations would be characterized by verbalizations such as "I can't do it myself" or "Make sure my kids get the insurance money," whereas expressive motivations would be illustrated by, "My life is hopeless," or "Soldiers never surrender" (1).

Additionally, studies have investigated risk factors associated with suicide by cop incidents (1,3,6-8). Although the research is not extensive, some common demographic, historical, behavioral, and situational variables have emerged. *Demographic* variables include being male (1,3,6) and typically being in one's twenties and thirties (6). With respect to *psychiatric and legal history*, a significant percentage of individuals who engage in "suicide by cop" behaviors have a notable history of suicidal ideation, self-abusive behavior, depression (1, 3,6), substance abuse (3,6), major psychiatric illness (3,6), and prior arrests (1,6). *Behavioral* factors include being demonstrative with firearms that are operative and loaded (3,6,8), using weapons with the apparent intent of shooting at police (1,6,8), taking hostages (1,6), being intoxicated on alcohol or drugs at the time of the incident (1,6), and leaving a suicide note or some communication of an intention to kill one's self prior to incident (6,9). Finally, *situational* variables involved in suicide by cop incidents have often included facing a stressful, shameful, or embarrassing life situation (1,6), and having had recent traumatic losses (6,7). Despite these known variables collected from various anecdotes, relatively little is known about persons who engage in

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suicide by cop incidents. To our knowledge, there has been no published in-depth research (including case studies) on instigators of suicide by cop who survived.

We present a case study of an individual who engaged in and lived through three separate “attempted suicide by cop” incidents. After describing relevant personal history as well as the events of the most recent incident in detail, we compare the case with the extant literature on suicide by cop and analyze commonalities and differences. Finally, we examine the legal considerations involved. In the case study presented, the affirmative defense of insanity was argued successfully.

Background History

Mr. P was born in South Dakota, the second child in a sibling strip of three. He reported that his childhood was marred by a history of physical and sexual abuse. Mr. P’s father, now deceased, worked as a tenant farmer. His mother was a homemaker until she suffered from Alzheimer’s disease and required placement in a nursing home. Mr. P was raised in the Midwest where he helped with the farming. He married Mrs. P, his wife of 39 years, during his second year of college. They reared three daughters. Mr. P described his children as being estranged due to his wife’s bouts with alcoholism. Prior to his most recent hospitalization, Mr. P resided with his wife in a small mid-western town, near his ailing mother.

Mr. P helped on the family farm until age 14 when he obtained outside employment. At age 18, he graduated from high school and entered the military. Mr. P reportedly worked as a “bookie” during his nine months of military service. He was honorably discharged from military service due to difficulties he was having associated with elbow surgery before his enlistment. He stated that the money he made running his gambling venture provided him with funds for college. He entered a state college at age 19 and graduated from college at 22 with a Bachelor of Science in education, and he worked as a teacher until he was 27. He later received a scholarship to a large private university where he completed a Master’s degree in education. Mr. P went on to complete coursework necessary for obtaining his doctorate; however, he never finished his doctoral dissertation.

Mr. P worked as a curriculum developer for six-and-a-half years. At 34 years old, Mr. P coordinated a curriculum for a kindergarten through 12th grade school. This position lasted until he was 40, when an accident occurred (described in detail below) leaving him with traumatic brain injury. Though he returned to work for another 13 years following the accident, he struggled. He was forced to retire at age 54.

Mr. P’s medical history showed that he was the product of a normal birth with no known complications. He reportedly met developmental milestones at appropriate times. Mr. P had the usual childhood illnesses and recovered with no residual symptoms. He had several surgeries including a tonsillectomy and an appendectomy. Reports indicate Mr. P sustained a concussion playing football at the age of 16. At the age of 39, Mr. P was a pedestrian walking near a road when he was struck by a motor vehicle causing a severe closed head injury with five starburst skull fractures. He was in a coma for eight days and required surgical placement of a plate in the right side of his skull. Mr. P reported gustatory and olfactory changes following this injury, specifically, experiencing noxious tastes and smells. He also described that his memory and math skills declined after the accident. Additionally, he was diagnosed as suffering from seizures during the years following the accident. Results from an electroencephalogram (EEG) showed some slowing of the right frontal parietal region consistent with the area

where the plate was surgically placed following his accident. In addition, Mr. P carried the diagnosis of narcolepsy. A recent brain scan found that Mr. P has some cortical atrophy that is most prevalent within the right temporal lobe followed by noticeable atrophy bilaterally in the frontal lobes.

Mr. P has a long history of substance abuse as well as a family history of alcoholism. His father, brothers, grandfather, and paternal uncles have known histories of alcohol dependence. His alcohol use began at age 13 and during his teenage years, he often binge drank. Following the accident resulting in traumatic brain injury, he became addicted to diazepam. He had abused several types of prescription drugs during his mid thirties and continued until he was 43. Mr. P qualified that he started going to Alcoholics Anonymous and Narcotics Anonymous at that time and has been substance abuse free ever since.

Since the traumatic brain injury at age 40, Mr. P began to have severe bouts of depression and episodes of rage approximately six months following the accident. There are no records suggesting that these symptoms existed premorbidly. Mr. P described these bouts as “extreme, extreme depression” and he has attempted suicide multiple times. Mr. P occasionally suffers “blackouts,” and cannot control himself when he becomes angry. Sometimes, he experiences feelings of euphoria, lasting for several hours, followed by depression. Mr. P does not suffer from a formal thought disorder, nor hallucinations or delusions. He carries diagnoses of Mood Disorder Due to Closed Head Injury, and Personality Change Due to Closed Head Injury, Combined Type, with Affective Lability, Behavioral Disinhibition and Aggression. He is prescribed medication to control symptoms of these disorders including mood stabilizers (divalproex sodium and gabapentin), antianxiety (clonazepam) and antidepressant medications (bupropion). Mr. P has been hospitalized a total of seven times for psychiatric problems since the accident (once for threatening police with a knife and twice for shooting at police). The treatment records call into question the efficacy of these medication regimens.

Testing of Mr. P’s mental functioning has shown that he typically is oriented to person, place, time and circumstance. Psychological testing of his personality functioning (with the Minnesota Multiphasic Personality Inventory-II) showed a significant elevation on the paranoia subscale. While this finding may typically suggest disturbed thinking with possible delusions of persecution, in this case, it seems to represent the expression of a person who feels lonely and quite misunderstood. In addition, he endorsed a number of items consistent with significant underlying depression, including signs of mental dullness, brooding, and periodic suicidal ideation. On another measure of personality functioning, (the Millon Clinical Multiaxial Inventory-III), there were indications of schizoid, narcissistic, masochistic, and dysthymic traits. Collectively, these results depict an individual who sees himself as a loner, often has a grandiose sense of self, and who periodically experiences anguished, erratic, and melancholic moods.

Intelligence testing revealed that Mr. P has overall intellectual abilities in the average range. His IQ score (Full Scale = 108) was better than 70% of the adult population, with verbal intellectual functioning exceeding 84% of the adult population. These scores are slightly lower than would be expected from a person who has doctorate level academic achievements. He may have suffered a decline in intellectual functioning from premorbid levels secondary to his traumatic brain injury and subsequent problems with persistent mental illness. Mr. P’s strong scores on tests of previously learned information and vocabulary usage support the hypothesis that he, at one time, had a higher premorbid intellectual capacity.

Neurocognitive testing showed that Mr. P has normal memory functioning. He was administered memory tests (e.g., the Wechsler Memory Scale-III) and his performance on immediate and delayed memory measures for both verbally and visually presented information fell in the average range. Yet, his score on the Working Memory Index was lower than expected; he exceeded only 27% of the normative sample. His concentration and attentional capacities were found to be within normal limits. However, on tests of “executive functions” (e.g., tests requiring planning and abstracting of learning principles), he showed significant impairment in mental flexibility and problem-solving skills (e.g., poor performance on the Booklet Category Test and the Wisconsin Card-Sorting Test). He was unable to abstract underlying concepts for the purpose of providing solutions to problems posed to him. Furthermore, he seemed to persist with ineffective problem-solving strategies even when given verbal feedback that such strategies were wrong.

Case Report

On the day before the attempted suicide by cop incident, Mr. P and his wife had traveled an hour’s distance away, to visit his mother at a nursing home. On the way back, he began thinking about his mother’s deteriorating condition and became depressed. He also obsessed about an argument he had with a family member earlier in the week. Later that evening, his wife, who is reportedly an alcoholic and was intoxicated at the time, began to “rage and scream” at him. This allegedly went on for some time. Mr. P reported that he kept “five” guns in the house and that they are “always there, loaded, and easily accessible.” He explained that he has kept the guns many years and had done so even before his head injury. He views them as a “protective measure.” That evening, he felt very frustrated and shot once through the roof of his living room in an apparent effort to make his wife discontinue “her antics.” She immediately left the house and called the police. At some point later, he viewed flashing lights in the distance. He hastily dressed, utilizing essentially inappropriate clothing and footwear for the happenings that followed. He got into a pickup truck and somehow managed to evade police who were parked at the end of his country road. He drove some five miles away to a “quiet place” in the woods, a place that he frequented over the years to “cool off.” The police pursued him and eventually discovered his whereabouts. There was some yelling between him and the officers, although he said that he did not understand or know what the police wanted from him. Nevertheless, he yelled at them and accused them of “violating his rights.” He described looking at the police on several occasions through the scope of a rifle (.22 caliber). Finally, Mr. P issued an ultimatum: they must leave him alone within 5 min or he would begin shooting at them. He said that during this time, he was feeling so depressed that he decided to end his life. He planned to have police kill him in a gun battle. He counted down the time and began firing his gun. The first shots hit the police cars, knocking out the spotlights. There was more gunfire exchange. Then, Mr. P grabbed his gun and began running further into the woods, firing as he retreated. There were some 14 or more shots fired by the police at Mr. P. Many of these shots hit his truck, behind which he had stood during the exchange of fire. He was tracked part of the time with a helicopter that had been called in to help police with the pursuit. Occasionally, the helicopter was able to locate him and at other times he evaded detection. He traveled a number of miles through woods. He finally came to an inhabited farmhouse and asked to use the phone. The resident farmer had heard about him over public media and denied Mr. P the use of the telephone. After he departed, the police were notified. Mr. P

walked down a country road and was eventually found, stopped, and held at gunpoint by the son of the farmer who had seen him earlier. Police arrived shortly thereafter and arrested him.

Mr. P related to the arresting officers that he wanted the police to shoot and kill him. He could not explain why he hid behind his truck, or decided later to run away. Interestingly, his description to the police (given subsequent to arrest) of wanting to die by their guns is nearly identical to an earlier incident that he perpetrated in another state years before. He described that during the time he was on his own in the woods after the confrontation with the police, he had fashioned a piece of string to the trigger of his gun and down around the butt of the gun, so he could pull it and kill himself. Though he apparently was in position to actually do this with the gun to his head, he never pulled the string.

Discussion

Since the closed head injury he sustained in 1979, Mr. P has demonstrated dangerous behavior on a number of occasions. Research has clearly shown that prior incidents of violence are one of the most robust predictors of future violence (10). As noted, he had a history of substance abuse which the literature suggests also may further predispose him to act out violently (11). His history of brain injury also increases his risk of violence (12). In particular, it appears that Mr. P’s aggressive episodes typically commence after a stressful event, such as his children threatening to cut off contact with him, fighting with his wife, or his mother taking a turn for the worse in her nursing home setting. It seems that his impaired cognitive functioning largely stemming from the traumatic brain injury makes it difficult, if not impossible, for Mr. P to change his mindset. He seems unable to generate appropriate alternatives for solving his problems. It should be noted that despite hospitalization and efforts at rehabilitation, Mr. P has continued to show poor coping skills for stress. At times, he continues to be threatening toward staff and peers. Also, he has required isolation from others as a self-management strategy for disruptive mood that seems to manifest itself without much warning or a specific identifiable precipitating event.

In the research literature on violent behavior, instrumental and expressive types of violence are often identified as two primary types of aggression with different causal mechanisms (13). Instrumental aggression is more likely to be present in criminals, especially psychopathic offenders, who have extensive histories of planned and premeditated criminal acts (14). Expressive violence, on the other hand, is a less stable trait and typically denotes aggression committed impulsively and without forethought (15). As a result of Mr. P’s mental inflexibility, he becomes frustrated, angry and depressed and enters into what he labels a “depressed rage” which often precipitates impulsive acting out, and sometimes, aggression. It is important to note that although Mr. P’s initial escalation in response to stress appears to be mostly reactive and automatic, his subsequent violence sometimes appears deliberate and planned (e.g., drawing police into a conflict so that they will shoot him). This indicates that his episodes of aggression are both seemingly instrumental and expressive in nature.

In Mr. P’s case, his violent behavior seems to stem mostly from a combination of his brain injury, subsequent mental illness and personality disorder. Historical records show that on three separate occasions, Mr. P has expressed suicidal ideation while simultaneously threatening police. As in other published cases, he has exhibited suicidal ideation and/or depressed behavior in the past, and a history of substance abuse and psychiatric hospitalization. Also, consistent with prior cases, he has pointed deadly weapons, either

knives or operative and loaded firearms, at the officers, and could not be dissuaded by police officers on the scene. Finally, each of Mr. P's suicide attempts by cop were preceded by significant stress, depression, and anger.

However, Mr. P's case shows some important differences from the extant literature. Most individuals described in published reports threatening "suicide by cop" are younger than Mr. P and have histories of arrests and incarcerations consistent with antisocial personality. Mr. P's traumatic brain injury distinguishes his case from others. In particular, when Mr. P confronts a stressful situation, he appears to get angry, depressed, rageful, and suicidal. But because of his cognitive inflexibility, he seems unable to generate alternative solutions for these problems. Instead, he continues to choose a maladaptive option he has used unsuccessfully in the past. It is as though a fixed action pattern is elicited in which he carries out a "suicide by cop" scenario, albeit with some restraints and ambivalence. Unlike most of the individuals described in studies of "suicide by cop," he did not broadcast his intentions (e.g., by letter), nor was he disinhibited secondary to alcohol and/or drug consumption. Rather, his acts appear to be extremely impulsive, poorly planned, and organically disinhibited. Theoretically, Mr. P's behaviors seem different from other reported suicide by cop cases.

In this case, Mr. P's apparent disorder in executive functioning speaks directly to issues of cognitive awareness and volition, both of which are critical considerations when investigating mental state issues relevant to the insanity defense. Repeatedly, he has exhibited deficits in self-regulation and control, including a deficient self-awareness concerning the impact of his behavior upon the larger socially relevant context. Specifically, he has marked difficulty identifying the implications of his behavior outside of the present, or legally relevant circumstances. Subsequent testing showed neuropsychological deficits on tasks requiring cognitive/behavioral shifts contingent upon corrective feedback. He appears to exhibit a classic executive dysfunction syndrome described in detail in the literature (16).

In consideration of the insanity defense, disorders of executive functioning imply potential deficits both within cognitive appraisals of behavior as well as management of volition. However, it is possible to have mostly intact cognitive capacities, but still have impaired management of volition due to frontal lobe impairment (17). Such a distinction is particularly relevant depending upon the insanity standard utilized within a particular jurisdiction. Many jurisdictions utilize guidelines strictly focusing upon cognitive appraisal of the alleged activity such as the McNaughten standard or part of the ALI standard (excluding the volitional component) used by the federal system. Other jurisdictions utilize the intact ALI standard focusing upon both cognitive appraisal and volitional management of the alleged criminal activity. Complicating the assessment is the difficulty separating how a person thought versus acted, as it is difficult to tease out motivational deficits from cognitive deficits (something the McNaughten standard in fact does by definition). The ALI standard keeps the cognitive and volitional components together. In situations such as this one in which it appears that the motivational and cognitive deficits are inseparable, a very liberal interpretation of the McNaughten insanity standard is required for one to qualify for the defense.

For this case, it was judged that Mr. P demonstrated behavioral dysregulation secondary to frontal lobe dysfunction. The available research suggests persons with executive dysfunction will repetitively engage in maladaptive behaviors when under great stress despite previously suffering negative consequences for the exhibition of such behavior (16). Executive dysfunctional persons may even be able to verbally articulate adaptive strategies, but still act out the

maladaptive behavior in a fixed manner, especially when confronted with stressful situations in vivo. In other words, they are cognitively rigid, "locked in" to carrying out a behavior with little possibility of inhibiting the maladaptive response. We believe that this cognitive disability impeded Mr. P's ability to consider truly the nature and consequences of his actions at the time of the criminal act, and thwarted his ability to consider more appropriate behavioral alternatives.

Conclusions

As with all cases related to the assessment of mental state at the time of the offense, this case poses many practical difficulties, including sorting the effect of co-morbid factors such as brain damage, depression, and personality factors. Moreover, the possibility of deliberate misrepresentation of the facts must be considered (18,19). The issue of "suicide by cop" further poses unique challenges. Practical difficulties exist when assessing the veracity of an individual's suicidal assertions when the individual also threatens or nearly completes a suicide by cop (particularly after surrender to law enforcement). It seems less obvious that an individual only intends to commit suicide if preceded by vengeful or retaliatory acts toward other people—again suggesting the need to assess contextual variables. Such behavior may appear strongly goal directed and deliberate, with full knowledge of its unlawfulness. Yet, the protagonist may simply not care about its legality or lack thereof, nor its consequences.

Finally, inherent difficulties exist when tying in neuropsychological data to criminal responsibility formulations. The reliability of such evidence is evaluated, in part, upon the validity of the scientific procedures and methods utilized in obtaining information. The challenges are particularly noteworthy, involving utilization of neuropsychological data that is presumably ecologically valid, and detailing the extent of neurocognitive dysfunction and its impact on behavior as it relates to the legal issue of criminal responsibility (17). Though research concerning the impact of executive function deficits on planned and goal-directed behavior has grown substantially over recent years (20), there clearly is a need for more scientifically rigorous research in this area.

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